



Phone (757)310-6900 Secure Fax (757)240-5936

### Authorization to Release Information to PRIMARY CARE PHYSICIAN

\*Patient Name: \_\_\_\_\_ \*Date of Birth: \_\_\_\_\_

I hereby authorize Coastal Medical and Psychiatric Services to obtain and disclose information regarding my care from:

\*Name of Agency/Provider: \_\_\_\_\_

\*Phone/Fax: \_\_\_\_\_

Dear \_\_\_\_\_,

Your patient was seen by me on \_\_\_\_\_. His/her plan of care includes:

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If you have any questions, please do not hesitate to contact our office.

Sincerely,

\*Print Patient Name and/or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\*Signature: \_\_\_\_\_

This release may remain valid until revoked in writing or until termination of care with either provider.